Medical History

Patient Name: _____ **Patient DOB:** _____/_____/_____

General Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

☐Y ☐N Under a physician's care now?: _____

☐Y ☐N Any hospitalization in the past 5 years?: _____

☐Y ☐N Any serious illnesses/surgeries?: _____

☐Y ☐N Use tobacco in any form?If yes, what type: _____

☐Y ☐N Is a **pre-medication** (antibiotic) required before dental visits due to a **heart condition** or **artificial joint(s)**?

Is there any reason why routine dental procedures might pose a risk to you, our staff, or other patients?

☐ Y ☐ N If yes, please describe: _____

Is there anything important about your medical condition we have not asked?

☐ Y ☐ N If yes, please describe: _____

Female Patients: ☐Y ☐N Currently nursing? ☐Y ☐N Currently pregnant? Due Date: _____/_____/_____

Are you allergic to or have had any adverse reaction to the following? (Check all that apply):

☐ **None**
☐ Aspirin
☐ Anesthetic - Local (type)
☐ Barbiturates
☐ Codeine
☐ Clindamycin
☐ Iodine
☐ Dairy
☐ Latex
☐ Metal Sensitivity
☐ Nitrous Oxide Gas
☐ Penicillin
☐ Sedatives
☐ Other Antibiotics (please list)
☐ Other – Please List:

_____

Are you currently taking medications for any of the following? (Check all that apply):

☐ **None**
☐ Antibiotics
☐ Antihistamines
☐ Anxiety
☐ Asthma
☐ Behavioral
☐ Blood Pressure
☐ Blood Thinners
☐ Cancer/Chemo
☐ Cholesterol
☐ Cortisone/Steroids
☐ Daily Aspirin
☐ Depression
☐ Diabetes
☐ Gastrointestinal
☐ Headache/Migraine
☐ Heart/Cardiac
☐ Insulin
☐ Muscle Relaxer
☐ Nausea
☐ Neurological
☐ Opioids
☐ Oral Contraceptives
☐ Osteoporosis
☐ Over the Counter Medications
☐ Pain
☐ Recreational Drugs
☐ Sleep/Sedatives
☐ Thyroid
☐ Urology
☐ Other:

_____

Have you had or currently have any of the following? (Check all that apply):

☐ **None**
☐ Acid Reflux
☐ ADHD
☐ AIDS/HIV
☐ Allergies
☐ Anemia
☐ Anorexia
☐ Anxiety
☐ Arthritis
☐ Artificial Heart Valve
☐ Artificial Joints
☐ Asthma
☐ Autism
☐ Autoimmune Disorder
☐ Bleeding Disorder
☐ Bulimia
☐ Cancer
☐ Cerebral
☐ Chemical Dependency
☐ Chest Pains
☐ Chicken Pox
☐ Convulsions
☐ COPD
☐ Depression
☐ Diabetes
☐ Dizziness
☐ Easily Winded
☐ Emphysema
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Frequent Ear Infections
☐ Frequent Headaches
☐ Frequently Tired
☐ Gastrointestinal
☐ Glaucoma
☐ Hay Fever
☐ Head Injuries
☐ Hearing Problems
☐ Heart Attack
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Leukemia
☐ Liver Disease
☐ Low Blood Pressure
☐ Mental Disorder
☐ Mitral Valve Prolapse
☐ Mononucleosis
☐ Neurological Disorder
☐ Psychiatric Treatment
☐ Radiation Therapy
☐ Respiratory Issues
☐ Rheumatic Fever
☐ Rheumatism
☐ Seizures
☐ Sinus Issues
☐ STD
☐ Stroke
☐ Swollen Ankles
☐ Thyroid Disorder
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Other:

_____

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Medical History

Have you experienced any of the following? (Check yes or no):

☐Y ☐N Bleeding gums while brushing/flossing
☐Y ☐N Tooth sensitivity to hot/cold
☐Y ☐N Tooth sensitivity to sweet/sour
☐Y ☐N Pain in any of your teeth
☐Y ☐N Sores or lumps in or near mouth
☐Y ☐N Have you had any head, neck, and/or jaw injuries
☐Y ☐N Jaw Clicking
☐Y ☐N Jaw Pain
☐Y ☐N Difficulty opening/closing jaw
☐Y ☐N Difficulty chewing

☐Y ☐N Frequent headaches
☐Y ☐N Clench/grind teeth
☐Y ☐N Lip/cheek biting
☐Y ☐N Difficult past tooth extractions
☐Y ☐N Prolonged bleeding following tooth extractions
☐Y ☐N Orthodontic treatment – date completed: _____
☐Y ☐N Do you wear dentures – date received: _____
☐Y ☐N Have you ever received oral hygiene instructions
☐Y ☐N Do you like your smile

Please list all medications you are currently taking. Include name, dosage, and the type/reason:

Medication Name	Dosage	Reason Prescribed

Patient Consent: To the best of my knowledge, all of the preceding answers are correct. If I have any changes in the status of my health or if my medications change, I shall inform the dentist and staff at the next appointment without fail.

☐ **Self** (patient) ☐ **Guardian**

Signature: _____ **Date**: _____/_____/_____

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